

**DENTIST STATEMENT OF CLAIM**

**Insured Information**

- DENTIST'S PRE-TREATMENT ESTIMATE  
 DENTIST'S STATEMENT OF ACTUAL SERVICES

Name of Policyholder	Policy no.	Class (if applicable)
Name of Insured	Email Address	
Name of Patient (If other than above)	Relationship to Insured	
Address	Telephone no.	
Is patient covered by another plan? <input type="checkbox"/> NO <input type="checkbox"/> YES      If yes, state dental plan name, group no. and name and address of carrier.		

**Dentist Information**

Dentist's Name, Address, and Phone No.							
First visit date for current series	Place of Treatment	Office	Hosp	ECF	Other	Radiographs or model enclosed? <input type="checkbox"/> NO <input type="checkbox"/> YES      How many?	
Is treatment result of occupational illness or injury? <input type="checkbox"/> NO <input type="checkbox"/> YES      If yes, enter brief description and dates							
Is treatment result of an auto accident or other accident? <input type="checkbox"/> NO <input type="checkbox"/> YES      If yes, enter brief description and dates							
If prosthesis, is this an initial placement? <input type="checkbox"/> NO <input type="checkbox"/> YES      If no, reason for replacement and date of prior placement							
Is treatment for orthodontics? <input type="checkbox"/> NO <input type="checkbox"/> YES      Enter date of initial placement and months of treatment remaining							
Date	Tooth No.	Surface	Description Of Service Including X-Rays, Prophylaxis, materials used etc. Line No.		Procedure No.	Fee	For admin use
Total Fee Submitted							

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Dentist)

Date

## Reimbursement

How do you wish reimbursement to be made?	Cheque <input type="checkbox"/>	Direct Deposit <input type="checkbox"/>	Wire Transfer <input type="checkbox"/>
<b>If Direct Deposit:</b>	Name of Bank _____	Bank Number _____	
	Branch Address _____	Transit Number _____	
	Name of Account Holder _____	Account Number _____	
<b>If Wire Transfer:</b>	Name of Bank _____	Bank I.D. (Swift Code) _____	
	Branch Address _____		
	Account Number _____	Currency of Account _____	
	Name of Claimant _____	Account Number (IBAN) _____	
	Residence Address of Account Holder _____		

## Signature and Athorization

I have reviewed the following treatment plan and I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.	I hereby assign my benefits payable from this claim to the named Dentist and authorize payment directly to him/her.
_____ Signature (Patient or parent if minor)	_____ Signature (Insured Person)
_____ Date	_____ Date